Their One Best Second Chance: Improving Community Reentry for Virginia's Incarcerated Youth

Most of the young people committed to Virginia's juvenile prisons have serious mental health needs. Most are non-violent offenders.

- 60% of males and 90% of females have diagnosed mental health treatment needs.
- 41% of males and 59% of females have *severe* emotional disturbances.
- 50% of youth have taken psychotropic medications prior to commitment.
- 25% have been hospitalized in mental hospitals prior to commitment.
- Approx. 75% are committed for non-violent offenses.

While in Department of Juvenile Justice (DJJ) locked facilities, Virginia invests valuable tax dollars in these young people, offering real opportunities for significant progress in their mental health treatment.

- Virginia taxpayers invest approximately $78,000 *PER YEAR* in *EACH* young person in DJJ.
- For the first time in their lives, these young people receive mental health care, proper diagnoses, and sustained medication management and monitoring—all the elements necessary to treat their problems and allow them to lead more successful lives.

BUT, when young people leave DJJ, they often fall through a needless gap between the mental health services in DJJ and those in the community—making our communities less safe and squandering taxpayers' investment in these youth.

- There is no requirement in Virginia law to have a mental health discharge plan for young people with mental health problems, <u>*even*</u> for those with serious mental illness. As a result, they often return home dependent on overburdened parole officers, an insufficient supply of medicine, and community mental health providers who are not expecting them.
- They typically face long waiting lists and other barriers that could be avoided if planning happened sooner and involved a mental health professional from the receiving community.
- Already, we do much more for other populations returning to their home communities. Local CSBs conduct "discharge planning" for children and adults leaving mental hospitals.[1] Treatment foster care providers must have a comprehensive plan 30 days prior to children leaving their care.[2] DMHMRSAS requires all its licensed providers to "make appropriate arrangements or referrals" in the discharge plan, *prior to* release.[3]
- We even do more for adults leaving adult prisons than we do for young people leaving DJJ.[4]

Reentry can be improved with minimal change in law and minimal cost.

- Improvement in this case does <u>not</u> require new services—only better connections between *existing* services.
- Studies show that this type of planning reduces recidivism.[5]
- There must be a plan. The right people need to be at the table, including a community mental health professional. Parents must be invited. The plan must be in place soon enough to make referrals and apply for services. Records must transfer. There must be *some* accountability and transparency. And, appropriate services must be in place and available very soon after a young person's release.

With minimal change to state law, we can insure better connections between existing services and fill the cracks of reentry. The following language will insure the necessary cooperation among agencies in coming up with an appropriate transition plan:

(12-14-04)

PROPOSED LANGUAGE, NEW CODE SECTION 16.1-293.1:

The Board of Juvenile Justice, after consultation with the Department of Mental Health, Mental Retardation, and Substance Abuse Services and other relevant agencies, including, at a minimum, the Departments of Correctional Education, Education, Medical Assistance Services, Rehabilitative Services, and Social Services, shall promulgate regulations for the planning and provision of post-release services for persons who are committed to the Department of Juvenile Justice pursuant to 16.1-278.8(14) or who are confined post-disposition pursuant 16.1-284.1 who have a mental health, substance abuse, or other therapeutic treatment need.

Such regulations will insure, at a minimum, the following:

1. A written treatment transition plan (hereinafter "plan") is completed prior to release.
2. Appropriate people will participate in the development of the plan, including, at a minimum, treatment professionals and other staff at the Department of Juvenile Justice who are familiar with the person's problems and needs, and a treatment professional or community service board representative from the community to which the person is returning.
3. Other appropriate people, including the person's parent(s), guardian(s), or other similar caregiver(s), are provided advance notice; are invited to participate in development of the plan; and receive a copy of the completed plan. At the discretion of the parent(s), guardians(s), caregiver(s), Department of Juvenile Justice, or, if he or she is of majority age, the person, other individuals may participate who have knowledge or expertise regarding the person. The determination of the knowledge or special expertise of any individual shall be made by the party (parent(s), guardian(s), caregiver(s), Department, or majority-age person) who invited the individual to be a member of the team.
4. The plan will consider the person's access to medication, medical insurance, disability benefits, and other social services and funding that must be accessed to insure his or her success in the community (hereinafter "supports"). The plan will specify what applications need to be completed and what referrals need to be made to obtain those supports.
5. The Department of Juvenile Justice, prior to the person's release, will make all referrals specified in the plan. The Department of Juvenile Justice, prior to the person's release, will assist the person to apply for services, insurance, and other supports identified in the plan, including those applications that may not be submitted prior to release.
6. The plan is completed early enough to insure continuity of necessary treatment and supports.

Please send comments and suggestions to
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[1] 12 Va. Admin. Code § 30-130-130(E) states:

> The long-stay acute care hospital shall coordinate discharge planning for the resident utilizing all available resources in an effort to assist the resident to maximize his potential for independence and self-sufficiency and to assure that services are being provided by the most effective level of care.

12 Va. Admin. Code § 5-290-30 states:

> Proposed acute psychiatric, acute substance abuse treatment, and intermediate care substance abuse treatment service providers should have formal agreements with community services boards in their identified service area which: (i) specify the number of charity care patient days which will be provided to the community service board; (ii) provide adequate mechanisms for the community services board to monitor compliance with charity care provisions; and (iii) provide for effective discharge planning for all patients (to include the return of patients to their place of origin/home state if other than Virginia).

See also 12 Va. Admin. Code § 30-50-420; 12 Va. Admin. Code § 30-50-430; 12 Va. Admin. Code § 30-50-440; 12 Va. Admin. Code § 30-50-450; 12 Va. Admin. Code § 30-50-490; 12 Va. Admin. Code § 35-105-690; 22 Va. Admin. Code § 42-10-630. *Cf.* 12 Va. Admin. Code § 30-60-120(H); 12 Va. Admin. Code § 30-60-147(A)(1)(i); 12 Va. Admin. Code § 35-105-860; 22 Va. Admin. Code § 40-71-160.

[2] For children in treatment foster care, 12 Va. Admin. Code § 30-130-940 requires the following:

> A. A discharge summary shall be developed for each child and placed in the child's record within 30 days of discharge. It shall include the date of and reason for discharge, the name of the person with whom the child was placed or to whom he was discharged, and a description of the services provided to the child and progress made while the child was in care. Written recommendations for aftercare shall be made for each child prior to the child's discharge. Such recommendations shall specify the nature, frequency, and duration of aftercare services to be provided to the child and the child's family.
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> B. The summary shall also include an evaluation of the progress made toward the child's treatment goals.
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> C. Discharge planning shall be developed with the treatment team and with the child, the child's parents or guardian, and the custodial agency.
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> D. Children in the custody of a local department of social services or private child-placing agency shall not be discharged without the knowledge, consultation, and notification of the custodial agency.

See also 12 Va. Admin. Code § 30-130-910.

[3] 12 Va. Admin. Code § 35-105-860.

[4] "Each institution with mental health services staff shall have written procedure and practice which establish the provision of mental health services to inmates and which address at least the following: . . . . 6. A system for continuity of care and follow-up procedures, including discharge planning." 6 Va. Admin. Code § 15-31-240 (2004).

"Other requirements for correctional facilities. . . . E. Aftercare planning for individuals nearing the end of incarceration shall include provision for continuing medication and follow-up services with area community services to facilitate successful reintegration into the community including specific appointment provided to the inmate no later than the day of release." 12 Va. Admin. Code § 35-105-1150.

[5] Eric Trupin et al. 2004. Transition Planning and Recidivism Among Mentally Ill Juvenile Offenders. *Behavioral Sciences and the Law*, 22: 599–610 (2004) ("Conclusions: Community transition planning, including the coordination and provision of community services, is an essential component of community reintegration for juvenile offenders and is associated with lower rates of recidivism during the first year post-discharge."). *See also* Programmatic and Non-programmatic Aspects of Successful Intervention, *in* A. Harland (Ed.), *Choosing Correctional Options that Work*. Thousand Oaks, CA: Sage Publications (Programs in community settings are more effective than those in institutional settings.); Palmer, T. (1996)); National Mental Health Association, Factsheet: Treatment Works for Youth in the Juvenile Justice System. http://www.nmha.org/children/justjuv /treatment.cfm (cited Nov. 7, 2004) ("Integrated Systems of Care," i.e., Wraparound Programs, such as Wraparound Milwaukee, have resulted in a 42% drop in the number of residential placements over the first two years of the program, representing a savings of $5.2 million.); Lipsey, M. (1992) (Evaluations show reduction of up to 61% in the number of crimes committed by youth on probation who are involved in "systems of care" programs.). Lipsey, M., & Wilson, D. (1998). Effective Intervention for serious juvenile offenders: A synthesis of research. In R. Loeber & D. Farrington (Eds.), *Serious and Violent Juvenile Offenders*. Sage Publications: Thousand Oaks, CA (Better outcomes are associated with the use of mental health professionals rather than corrections staff as the treatment providers.).